Research Article

Obstetric Violence in Mexico: Results From a 2016 National Household Survey

Violence Against Women
1–18

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Roberto Castro[1] **and Sonia M. Frías**[1]

Abstract

Obstetric violence has not received the same amount of interest as other forms of violence against women (VAW). We assess the prevalence and factors associated with experiences of obstetric violence (obstetric abuse and violence, and nonconsensual care) among women between 15 and 49 years of age in their latest childbirth within the last 5 years by using the 2016 National Survey on Household Relationship Dynamics. ($N = 24{,}126$ women). A total of 33.3% of Mexican women experienced obstetrical violence in their last childbirth: 23.6% experienced obstetric abuse and violence and 17.1% nonconsensual care. Gender interacts with other social stratification variables. Obstetric violence is an extended practice in health care services. It is a human rights problem that must be prevented and eradicated.

Keywords

obstetric violence, Mexico, reproductive rights, childbirth, ENDIREH, violence against women, mistreatment and abuse.

Introduction

The phenomenon of violence against women (VAW) and its consequences has received extensive attention from academia, national and regional-level governments, and international organizations. However, obstetric VAW as a gendered expression of mistreatment and abuse during childbirth has not received the same amount of interest as other contexts in which VAW takes place (Castro & Erviti, 2003; Pires Lucas d'Oliveira, Grilo Diniz, & Blima Schraiber, 2002; World Health Organization [WHO], 2015).

[1]National Autonomous University of Mexico, Cuernavaca, Mexico

Corresponding Author:
Roberto Castro, Regional Center for Multidisciplinary Research, National Autonomous University of Mexico, Av. Universidad s/n, Circuito 2, Colonia Chamilpa, Cuernavaca, Morelos 62210, Mexico.
Email: rcastro@correo.crim.unam.mx

In recent years, various studies have reported diverse forms of abuse and mistreatment during childbirth to be a prevalent phenomenon in many parts of the world such as Africa (Amroussia, Hernandez, Vives-Cases, & Goicolea, 2017; Chadwick, 2017), Asia (Diamond-Smith, Treleaven, Murthy, & Sudhinaraset, 2017; Raj et al., 2017), and Latin America (Castro & Erviti, 2003; Dixon, 2015; Junqueira de Souza et al., 2017; Montesinos-Segura et al., 2018; Smith-Oka, 2015). Most published research employs qualitative methodologies, which are useful to learn about the experience of women suffering this type of mistreatment as well as the specific processes constituting the abuse and mistreatment. However, such methods do not reveal the magnitude of the problem, nor do they allow researchers to make comparisons (Elmir, Schmied, Wilkes, & Jackson, 2010; Shakibazadeh et al., 2017).

Although quantitative studies have been conducted in some countries, they are based on samples that, in the best of cases, are representative of health care services users from a particular region or country. In 2016, the first national survey on obstetric violence was conducted in Italy, in which a sample of 424 mothers ranging from 20 to 60 years of age were asked about their experiences of obstetric violence during the birth of their first child (Battisti, Skoko, Ravaldi, & Cericco, 2017). Obstetric violence affected 21% of them. Quantitative studies are characterized by a diversity of methodological designs and operational strategies that could explain the huge range of "trends" found (literally ranging from 15% to 98%, Sando et al., 2017; Savage & Castro, 2017). Consequently, it has thus far been extremely difficult to ascertain the real dimensions of this problem and to make comparisons among countries.

This study presents the main results of the first measurement conducted anywhere in the world (to our knowledge) of the problem of obstetric violence through a probabilistic nationally representative household survey. The National Survey on the Dynamics of Household Relations (Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares, ENDIREH) is a longitudinal trend survey (2003, 2006, 2011, and 2016), which has evolved from a survey on domestic violence to a survey aimed at studying the various forms of VAW. The authors were part of the advisory committee for the fourth edition (2016) and stressed the importance of including a section on mistreatment and abuse during childbirth. Mistreatment and abuse during childbirth has been conceptualized as obstetric violence since 1998 in Mexico (Castro & Erviti, 2014). The items to be included in this section took as a starting point previous qualitative research in Mexico (Castro & Erviti, 2003) together with the dimensions of abuse and mistreatment identified by Bowser and Hill (2010).[1]

We suggested specific questions to assess prevalence in different dimensions. However, only nonconsensual care, undignified care, and abandonment of care were included in the survey. It is likely that the four remaining dimensions were not included, among others, for the following reasons: (a) in published research using Mexican data, there is no empirical evidence of events of physical abuse during childbirth, such as slapping and hitting, as found in other countries (Bohren et al., 2016); (b) in public health care facilities, labor rooms are shared as women are transferred to a private room only when they are about to give birth; (c) discrimination based on specific patient attributes was not included because public health care services must provide

care for all women (age, ethnic, and racial discrimination tends to be evidenced through verbal abuse); and (d) there is no empirical evidence of detention in public facilities due to lack of payment, especially because care in public facilities is free.

In the first section, "Background," we present background on the phenomenon of abuse and mistreatment during childbirth, examining its conceptual development and the main studies reported from various countries. In the second section, "Method," we explain the methodology and analytical strategy to examine the prevalence of this phenomenon and its associated factors. Finally, in the third section, "Expressions of Obstetric Violence at Childbirth Among Mexican Women," our main results regarding abuse and violence and the nonconsensual care reported by women are shown. Finally, conclusions, implications, and limitations of this research are presented.

Background

The problems of obstetric violence and abuse and disrespect of women during childbirth have received much interest in many countries globally. In 1998, the Latin American and Caribbean Committee for the Defense of Women's Rights documented various forms of VAW in the Peruvian public health care services as well as the forced sterilization of many women under the Fujimori administration (CLADEM, 1998, 1999). At the beginning of this century, attention was drawn to obstetrical violence as an emerging problem in health care services and as a human rights problem.

Observers have pointed to the need to challenge the traditional paradigm of doctors deciding how to attend childbirth and women simply obeying (Lokugamage & Pathberiya, 2017). In this paradigm, women are subjected to different practices that can be conceptualized as violence in their relations with health care services providers. These practices have been termed abuse and mistreatment. Freedman et al. (2014, p. 916) defined it "as interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified." Seven different expressions are conceptually included in abuse and mistreatment: (a) physical abuse, (b) nonconsensual care, (c) nonconfidential care, (d) undignified care (which includes verbal abuse), (e) discrimination based on specific patient attributes, (f) abandonment of care, and (g) detention in facilities. In addition, others have expanded Bowser and Hill's (2010) classification based on specific behaviors of service providers to include the structural dimension, related to a hostile or discriminatory environment. The World Health Organization (WHO, 2015) issued a statement indicating that disrespectful and abusive treatment during childbirth includes practices such as

> physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violation of privacy, refusal of admission to healthcare facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay. (p. 1)

The WHO stressed that certain types of women (adolescents, unmarried women, women of low socioeconomic status, women belonging to ethnic minorities) are at a higher risk of experiencing disrespect and abuse; furthermore, there is not yet an international consensus on how this problem should be scientifically defined and measured.

The mistreatment and abuse of women during childbirth is a problem involving gender as well as human and reproductive rights. Therefore, the literature also refers to "obstetric violence." The concept arose at the end of the 20th century in Latin America to refer to the problem's structural nature and to emphasize that it is a specific type of gendered VAW (Sadler et al., 2016). This perspective (which adds the component of structural gender inequality) found a decisive boost in Brazil, where the Humanization of Childbirth movement began as well as the Latin American Network for the Humanization of Childbirth (Vera-López, 2010). At the beginning, there was consensus to not call the problem "obstetric violence" so as not to hinder partnerships with health care providers who are needed to change this problem (Diniz et al., 2015). However, there was a turning point when this phenomenon was legally defined in Venezuela as

> . . . the appropriation of a woman's body and reproductive processes by personnel, expressed as dehumanizing treatment, an abuse of medication, and the pathologization of natural processes, bringing about a loss of autonomy and the capacity to freely decide about their bodies and sexuality, negatively impacting the quality of life of women. (Venezuela's National Assembly, 2007)[2]

Since then, there have been persistent calls to conceptualize obstetric violence as a specific type of gender violence affecting women, rather than as a problem of poor-quality health care service or mistreatment and abuse in health care services that might affect any patient (Bellón Sánchez, 2015; Shabot, 2016). This perspective, which is adopted in our study, allows mistreatment and abuse to be studied in the broader context of the various types of violence suffered by women.

Situation in Mexico

Bronfman and Castro found an unusual concentration of sterilizations among the indigenous population compared to the nonindigenous population in Mexico since the end of the 20th century (Bronfman & Castro, 1989). They hypothesized that the operations took place as coercive procedures rather than with informed consent, that is, under what we now call obstetric violence.

In Mexico, obstetric violence has been researched primarily from a qualitative standpoint to determine its occurrence in labor and delivery rooms, to document the authoritarian attitudes of obstetrics and gynecology health care personnel, to describe the experiences of indigenous women in obstetric violence, and to study the resistance strategies employed by women experiencing obstetric violence (Castro & Erviti, 2003; Erviti, Collado, & Castro, 2004).

The prevalence and extent of the phenomenon is evidenced by data from the National Medical Arbitration Committee (CONAMED) confirming that obstetrics and gynecology care is one of three medical specialties that receives the most complaints, the other two being emergency services and traumatology, and orthopedics. Clearly, these statistics are not directly indicative of obstetric violence, but they do point to a serious problem in the care provided. In addition, the National Committee on Human Rights (CNDH) issued General Recommendation 31 on Obstetric Violence in early 2017, noting that the number of complaints on this subject over the last 20 years undeniably indicates a serious problem of obstetric violence in health care services (CNDH, 2017). Further evidence of the prevalence of the phenomenon is offered by nongovernmental organizations that report data on legal counsel for women who had experienced obstetric violence. Based on official sources, these organizations reported 719 cases from 2009 to mid-2012, and 297 cases from mid-2012 to the end of 2013 (Grupo de Información en Reproducción Elegida, 2013, 2015). However, Mexico still lacks reliable data regarding the prevalence of the phenomenon and associated factors.

The problem captured the attention of the news media and of public authorities, likely due to two events. First, one of the authors received the 2014 Iberoamerican Prize in Social Sciences for research work on the origin and diverse manner in which the authoritarianism of health care personnel occurs during childbirth care (Castro, 2014a; Castro & Erviti, 2015). In fact, the aforementioned CNDH General Recommendation 31 is largely based on that author's research. The second trigger was a series of unfortunate episodes in which indigenous women were forced to give birth in the garden, hallway, or waiting room of health care services due to delays by staff in admitting them, which received widespread coverage in the news media.

Method

The 2016 ENDIREH is a household survey representative of all Mexican women 15 years of age and older–45.2 million according to the 2015 Intercensal Survey–regardless of marital status ($N = 111{,}256$). In addition, the survey is representative of each of the 32 states that comprise Mexico. Respondents aged between 15 and 49 were asked whether they had a pregnancy and gave birth during the previous 5 years (from October 2011 to 2016). A total of 31.4% of the sample of women aged between 15 and 49 answered in the affirmative ($N = 24{,}126$). About 62 women reported that nobody helped them during the last childbirth. Therefore, they were excluded from the final sample ($N = 24{,}064$).

Dependent Variables

Respondents were asked several questions regarding their experiences during their last childbirth regarding physical abuse, nonconsented care, nondignified care, and abandonment of care–categories and concepts identified in previous works (Bohren et al., 2015; Bowser & Hill, 2010; Freedman et al., 2014). Two items measured physical abuse: (a) Were you forced to stay in an annoying or uncomfortable position? (b) Did

they refuse to anesthetize you or apply a pain blocker without providing any explanation? Two items tackled nondignified care: (c) Did they yell at you or scold you? (d) Did they say offensive or humiliating things (e.g., "Is that how you screamed when he did that to you?" or "When he did it, you opened your legs all right, didn't you?"). Abandonment of care was captured through three items: (e) Were you ignored when you asked things about your delivery or about your baby? (f) Did they take a long time to assist you, saying that you were screaming or complaining a lot? (g) Were you prevented from seeing, holding, or breastfeeding your baby for more than 5 hours for no reason or without being told of a reason for the delay? Five items measured nonconsented care: (h) Were you sterilized, given a contraceptive, or had an IUD (intrauterine device) inserted, or had surgery to prevent you from having more children without being asked or letting you know? (i) Were you pressured to accept the insertion of an IUD or an operation to prevent further pregnancies? (j) Were you obliged or threatened to sign a piece of paper without being told what it was or what it was for? Two additional questions were asked only to women who had a C-section: (k) Were you informed in such a way for you to understand why a C-section was necessary? (l) Did you give permission or authorization for the C-section?

First, we conducted a factor analysis to identify the underlying dimensions of the phenomenon of obstetric violence (analyses not shown). We identified two main factors: *abuse and violence* and *nonconsented care. Abuse and violence* include the abovementioned items related to physical abuse, nondignified care, and abandonment of care. The question regarding whether a woman was not allowed to see, hold, or breastfeed her baby for more than 5 hours without any reason or explanation (3.2% of women) was excluded from the analyses because it was not related to any of the factors. A woman is considered to have experienced *abuse and violence* (23.6% of the sample) if she provided an affirmative answer to any of the items (Cronbach's $\alpha = .78$). A second factor emerged from the analysis, *Nonconsented Care*, which is associated with authoritarian procedures aimed at imposing temporary or permanent contraception and/or performing a C-section. The variable *Nonconsented Care* (17.1% of the sample) assesses whether the respondent went through any of the situations measured in items 7 to 11 (Cronbach's $\alpha = .48$). We created an additional variable, *obstetric violence*, which measures whether women experienced any event of *abuse and violence* or *nonconsented care* (Cronbach's $\alpha = .73$), which represents 33.3% of the sample.

Independent Variables

The ENDIREH 2016 also allows us to identify several individual, sociodemographic, and institutional factors that might be associated with obstetric abuse and violence and nonconsented care. Of the demographic variables, a woman's *age* and *years of education* are continuous variables that are measured in years. The *number of children born alive* is a continuous variable. *Indigenous ethnicity* is a dichotomous variable that measures whether a woman speaks an indigenous language. By measuring whether the woman speaks an indigenous language in addition to or instead of Spanish, we created

a proxy that allows us to identify individuals with an indigenous background. Marital status has three categories that assess whether women were (a) married or in a common-law union; (b) divorced, separated, or widowed; or (c) single at childbirth. Several recodes that involved the length of marriage/union were conducted because marital status was only recorded at the time the survey was conducted.

The measure of *socioeconomic status* follows the classification scheme developed by Echarri (2014) which is based on three household characteristics. The first characteristic is the average years of education of the household members, the second refers to the occupational status of the household member with the highest potential income based on the average for that occupation, and the third involves basic household amenities. Based on these three characteristics, each household is assigned to one of four economic strata: very low, low, medium, or high.

Employment is coded as 1 if the respondent worked for pay and 0 otherwise. *Urban* is a dichotomous variable that assesses whether the woman currently lives in an urban setting of more than 2,500 inhabitants (coded 1) or in a rural area (coded 0). Recipient of Prospera (a public conditional cash-transfer program aimed at alleviating poverty, details in Gil-García, 2016) is also a dichotomous variable that identifies women who receive the benefits of this program. This variable is included because previous research identified forced sterilization among female recipients of federal programs addressing education, health care, and food programs among underprivileged populations. Finally, *time elapsed since childbirth* is a continuous variable that retrospectively measures the number of years since the last childbirth. This variable might capture both changes in the practices among health care providers as well as the possibility of having been able to identify certain events such as an unknown sterilization.

Regarding institutional variables, *place of childbirth* is a variable with seven categories that assesses whether the childbirth occurred in a (a) community health care center, (b) IMSS (federal public health care facility), (c) ISSSTE (governmental employees' health care facility), (d) State public health care facility, (e) private health care facility, or (f) other (see Castro, 2014b for details on the health care delivery system in Mexico).

Analytical Strategy

The analysis unfolds in three steps. First, descriptive analysis of the phenomenon; second, bivariate analysis of the factors associated; and, third, a set of logistic regression analyses examines the variables associated with *obstetric violence and abuse* and *obstetric nonconsented care.*

Expressions of Obstetric Violence at Childbirth Among Mexican Women

Around 8.7 million Mexican women aged 15 to 49 had a child born alive in the last 5 years (26.7%). Of these, 43% delivered by C-section in their last childbirth. As shown in Table 1, 23.6% of these women experienced obstetric abuse and violence, and

Table 1. Acts Comprising Obstetric Violence Against Women in Mexico.

	%
Abuse and violence	23.6
Forced to remain in an uncomfortable or painful position.	9.2
Yelled at or scolded.	11.2
Told offensive or humiliating things.	7.0
Ignored when asking about the labor or baby.	9.9
Refused anesthetic or a pain blocker to decrease the pain without any explanation.	4.8
A long delay to attend you, saying that it was because you were screaming or complaining a lot.	10.3
Nonconsented care	17.1
Inserted a contraceptive or sterilized you without asking or advising.	4.2
Pressured you to accept an IUD or an operation.	9.3
Forced you to sign a paper.	1.6
Did not inform you that a C-section[a] was necessary.	10.3
You did not give permission for a C-section[a].	9.7
Any of above	33.3

Source. Authors' calculations based on the 2016 ENDIREH data.
Note. IUD = intra-uterine device; ENDIREH = Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares.
[a]This percentage refers only to those whose last childbirth entailed a C-section.

17.1% nonconsented care. More specifically, 11.2% were yelled at or scolded; 10.3% revealed that health service providers delayed care, arguing she bawled or moaned a lot; 9.9% had health care personnel ignore their questions regarding the labor or newborn; 9.2% were forced to stay in an annoying or uncomfortable position; and 7% bore insults or humiliations.

Regarding nonconsented care, 9.3% of the sample disclosed being pressured to accept the insertion of an IUD or an operation to prevent further pregnancies, whereas 4.2% received one of these two procedures without having been so informed or without their having consented. This figure is conservative because women might not be aware that they experienced some of these medical procedures. A total of 1.6% reported having been forced to sign a paper without knowing what it was about. Finally, among women who received a C-section, 10.3% reported they were not clearly informed of why it was needed, and 9.7% did not grant permission for a cesarean. Among the latter, the consent was provided mostly by the woman's husband or partner (57.3%), followed by a woman's relative (19.3%), and other people (7.3%); 15.8% reported that nobody consented to the C-section (analyses not shown). This figure might not only partially account for emergency cesareans, but it might also be related to authoritarian medical practices. Overall, 32.2% of Mexican women who gave birth in the last 5 years experienced one or more of the above-mentioned expressions of obstetric violence during their last childbirth.

Factors Associated with Obstetric Violence and Abuse and Obstetric Nonconsented Care

Table 2 examines sociodemographic and institutional factors associated with the experience of obstetric violence and nonconsented care. Obstetric abuse and violence as well as nonconsensual care were significantly less prevalent among women who were married or in a common-law relationship at childbirth than among those without a partner at the time. For example, violence and abuse were reported by 23.2% of partnered women versus 25.7% of separated, divorced, or widowed women. Nonconsented care was also more prevalent among single women than among those married or cohabiting (19.3% vs. 16.9%). This is unlikely to be related to the presence of male partners in the delivery rooms because they are not allowed in Mexican public hospitals. Possible explanations should be sought, we surmise, in the prejudiced care doctors might provide to single "unchaste" mothers deemed irresponsible as compared to women with an identified partner (either married or cohabiting; see Betron, McClair, Currie, & Banerjee, 2018).

Both obstetric abuse and violence and nonconsented care are more prevalent among younger and urban women ($>$ 2,500 inhabitants), those who do not speak an indigenous language, and those socioeconomically underprivileged than among their older, rural, more privileged, and indigenous counterparts. For example, 17.3% of females who only speak Spanish experienced nonconsented care versus 14.9% of females who speak an indigenous language instead of or in addition to Spanish. Employment status, the number of children born alive, and time elapsed since childbirth are not associated with violence and abuse and nonconsented care.

Other sociodemographic variables are associated only with one of the two dimensions of obstetric violence. Reports of obstetric abuse and violence tend to be higher among better-educated women. Recipients of the Prospera program reported a significantly lower prevalence of nonconsensual care than nonrecipients. These findings need to be interpreted with care because it is likely that the identification of expressions of obstetric violence is more difficult among women in more disadvantaged situations (indigenous, less educated, and in rural settings).

Among women whose last child was born in a State public hospital or the Mexican Social Security Institute, there is more prevalence of both obstetric abuse (around 29% in both) and violence and nonconsensual care (18.7% and 22.9%, respectively), followed by community public health centers (26.3% and 16.7%, respectively). The reported prevalence of obstetric abuse and violence and nonconsented care among women who sought care in private facilities is lower but non-negligible (8.8% and 9.5%).

Table 3 presents the odds ratios from two models of logistic regressions predicting the experiences of obstetric abuse and violence as well as nonconsented care. Regarding abuse and violence (Model 1), regardless of the marital status at childbirth, socioeconomic status, being employed, and being a recipient of the conditional cash-transfer program (Prospera), women are at the same risk of having suffered obstetric abuse and violence during their last childbirth. However, as the woman's age increases, the

Table 2. Factors Associated With the Prevalence of Different Forms of Obstetric Violence Against Mexican Women (Averages and Frequencies).

	Abuse and violence		Nonconsented care		Col. %
Sociodemographic characteristics					
Marital status at childbirth		*		*	
Married or common-law relationship	23.2		16.9		81.9
Separated, divorced, or widowed	25.7		17.4		10.9
Single	25.0		19.3		7.1
Indigenous ethnicity		***		*	
No	23.9		17.3		92.9
Yes	19.9		14.9		7.1
Age (in years)		***		***	
No	28.7		28.6		
	6.3		*6.2*		
Yes	27.6		27.6		
	6.3		*6.4*		
Years of schooling		*			
No	10.1		10.1		
	3.6		3.5		
Yes	10.1		10.1		
	3.6		3.5		
Socioeconomic status		***		***	
Very low	22.1		16.3		24.4
Low	25.2		18.0		50.0
Medium	23.2		17.1		16.4
High	19.0		14.5		9.2
Number of children born alive					
No	1.3		1.3		
	0.6		*0.6*		
Yes	1.3		1.3		
	0.6		*0.6*		
Employed					
No	23.4		16.9		62.8
Yes	23.9		17.4		37.2
Spheres of residence		***		***	
Rural	21.3		15.4		26.4
Urban	24.4		17.7		73.6
Recipient of Prospera				***	
No	23.8		17.5		86.5
Yes	22.4		14.9		13.5
Institutional and childbirth factors					
Time elapsed since childbirth (years)					
No	1.7		1.7		

(continued)

Table 2. (continued)

	Abuse and violence		Nonconsented care		Col. %
	1.2		*1.2*		
Yes	1.8		1.8		
	1.3		*1.2*		
Institution where childbirth took place		***		***	
Community health center	26.3		16.7		10.4
IMSS	28.7		22.9		26.1
ISSSTE	20.5		15.6		2.4
State(s) public hospital	29.1		18.7		37.2
Private hospital or facility	8.8		9.5		19.4
Midwife or healer	3.4		1.8		2.6
Other	12.2		13.3		1.8
	23.6		17.1		

Source. Authors calculations based on the 2016 ENDIREH.
Note. Standard deviations for continuous variables are in *italics*. IMSS = Mexican Social Security Institute; ISSSTE = Institute for Social Security and Services for State Workers; ENDIREH = Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares.
*$p < .05$. **$p < .001$. ***$p < .0001$.

Table 3. Logistic Regression Models of the Predictors of the Factors Associated With Obstetric Abuse and Violence, and Nonconsented Care During Last Childbirth Within the Last 5 Years.

	Abuse and violence[a] Odds ratio e^{β}		Nonconsented care[b] Odds ratio e^{β}	
Intercept	−2.27	***	−2.14	***
Sociodemographic				
Marital status at childbirth (married or cohabitating)				
Single	0.93		1.03	
Separated, divorced, widow	1.56		1.06	
Speaks an indigenous language	0.87	†	1.07	
Age	0.98	***	.98	***
Years of schooling	1.02	*	1.01	†
SES (high)				
Very low	0.90		1.13	
Low	0.96		1.10	
Medium	0.99		1.10	
Employed	1.02		1.03	
Recipient of Prospera	1.03		0.95	
Urban setting (rural)	1.25	***	1.21	***
Number of children born alive	1.11	**	0.99	

(continued)

Table 3. (continued)

	Abuse and violence[a] Odds ratio e^{β}		Nonconsented care[b] Odds ratio e^{β}	
Institutional factors				
Time elapsed since childbirth	1.05	**	1.04	*
Place of childbirth (private hospital or facility)				
Community health center	4.08	***	1.98	***
IMSS	4.37	***	2.90	***
ISSSTE	3.03	***	1.83	***
State(s) public hospital	4.66	***	2.31	***
Other	1.02		0.68	**
–2 Log likelihood	18,283.2		15	

Source. Own calculations based on 2016 ENDIREH.
Note. Reference categories are in parentheses. SES = Socioeconomic status; IMSS = Mexican Social Security Institute; ISSSTE = Institute for Social Security and Services for State Workers; ENDIREH = Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares.
[a]5,402 women reported having been subjected to an act of abuse or violence, and 18,620 reported they had not.
[b]3,876 women reported having been subjected to unauthorized care, and 20,146 reported they had not.
$^{\dagger}p < .10$. $^{*}p < .05$. $^{**}p < .001$. $^{***}p < .0001$.

relative risk of having experienced obstetric abuse and violence decreases (2% for each additional year of age). Conversely, as women achieved higher levels of schooling, the relative risk of reporting obstetric abuse and violence increases (2% for each additional year of schooling). The number of children born alive and residing in an urban setting also increase the risk of having experienced obstetric abuse and violence (by 11% and 25%, respectively). The former might be associated with having another experience to compare the most recent one to. Finally, women who received care in public health care services are invariably at a higher risk of experiencing obstetric violence and abuse compared to those delivering in a private facility or hospital. For example, compared to women delivering in a private hospital or facility, those who received care at a State public hospital had a 366% higher risk of experiencing obstetric violence and abuse, 337% higher at the IMSS, 308% higher at a community health care center, and 203% higher at the ISSSTE.

Model 2 examines nonconsented care. As in Model 1, marital status, socioeconomic status, being employed, and being a recipient of the Prospera program are not associated with nonconsented care. Although speaking an indigenous language and the number of children born alive were positively associated with obstetric violence and abuse, in this sample they are not associated with nonconsented care. The only sociodemographic variables statistically linked are age (for each additional year of age, the risk decreases by 2%), schooling (for each additional year of schooling, the risk increases by 1%), and residing in an urban area (the relative risk increases by 21%). Similarly, receiving obstetric care in a public institution, compared to those who

went to a private hospital or facility, invariably increases the risk of experiencing nonconsented care. For instance, women who received care at the IMSS had a 190% higher risk of obstetric nonconsented care than those who went to a private facility. Women who reported other types of care (which included midwives and healers) had a 32% lower risk of experiencing obstetric nonconsented care.

Finally, in both models, the variable *time elapsed since childbirth* has a positive and significant relationship with the phenomenon studied. By each additional year elapsed since the childbirth, women had a 5% greater likelihood of reporting having experienced obstetric abuse and violence, and a 4% greater likelihood of having experienced nonconsented care. Although it might be that obstetric violence has decreased over time as public recognition and media coverage has increased, it might also be the case that women currently have more resources to identify negative experiences during childbirth. It may also be that, as time passes, women can more clearly understand whether they suffered abuse and mistreatment during childbirth. This is particularly true because they have distanced themselves from any form of emotional overload associated with the childbirth itself, allowing them to be aware of what constituted mistreatment.

Discussion and Limitations

Obstetric violence undoubtedly constitutes a significant problem in the context of human rights and the struggle against gender-based violence and VAW. This study offers a relevant contribution in the study of the magnitude and variables associated with obstetric violence. Although surveys on this topic have been conducted in other countries, none has measured the phenomenon with a probabilistic sample of households nor with the level of representativity as in this study using the 2016 ENDIREH.

The results of this study show that one-third (33.3%) of Mexican women aged 15 to 49 who had a childbirth during the last 5 years experienced obstetric violence: 23.6% experienced obstetric abuse and violence and 17.1% nonconsented care. These data are conservative because women were only asked about their most recent delivery. It is plausible that women might have experienced the specific events under study in other childbirth experiences but not in the latest. Based on these results, we claim that millions of women in Mexico have experienced this problem, in both private and public health care institutions.

This study also highlights the high prevalence of C-sections among Mexican women, both in private and public facilities. Two-thirds of women (67.7%) whose delivery occurred in private facilities and 52.4% of those who went to the ISSSTE gave birth by C-section. Future studies should examine in greater detail the relationship between nonconsented care and the high prevalence of C-sections in Mexico, which ranks second among countries with the highest rate of C-sections in America, behind Brazil (Boerma et al., 2018).

The limitations in this study include that the measurement of some of the covariates might not necessarily correspond with the time of childbirth; the problem of the age cut-off (15 to 49), which excludes women aged 50 to 54, who might also have given

birth in the previous 5 years; the problem of the nonexhaustive nature of the questions, which did not include questions on topics (such as unnecessary episiotomies) that can also be viewed as forms of violence; and the problem of memory, which can impact the report of women's experiences (i.e., underreporting).

This study has several implications in terms of public policy. First, the problem affects a very significant proportion of women of child-bearing age. Interventions in public health care services must reduce and, if possible, eliminate the abuse and mistreatment that so many women suffer in health care services. Second, various studies published to date in different countries have led to legal attempts to combat the problem of abuse and mistreatment during childbirth (Dunn, Lesyna, & Zaret, 2017; George & Branchini, 2017; Herrera-Vacaflor, 2016). However, the issue is still under legal construction given that the full identification of the rights violated is closely tied to the correct identification and measurement of practices that can be considered as violating rights. The results of this study contribute to identifying the most prevalent practices of obstetric abuse and mistreatment in Mexico, which might eventually be considered from a legal standpoint as well. Third, the 2016 ENDIREH is a survey on VAW. Since it includes a section on obstetric violence, that survey and the results of this study reinforce the argument that the abuse and mistreatment of women during childbirth (obstetric violence) is, above all, another form of gender-based violence and VAW, exercised solely against women, and exercised when women are in a particularly vulnerable state. Therefore, the results of this work should also be considered when designing policies to prevent and eradicate VAW in any of its forms.

Finally, this survey was conducted by the Mexican State. It is crucial for women's rights and for the elimination of all forms of VAW that governments around the world gather data on the quality and conditions of maternal health services from the point of view of women. States should aspire to conduct and promote such surveys, or include a section on obstetric violence in current VAW survey instruments, to retrieve information on all types of VAW and factors associated with it. This information should inform VAW prevention and protection policies.

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Notes

1. These dimensions are (a) physical abuse, (b) nonconsensual care, (c) nonconfidential care, (d) undignified care, (e) discrimination based on specific patient attributes, (f) abandonment of care, and (g) detention in facilities.

2. Based on the definition of obstetric violence originally proposed by Venezuela, 11 of the 32 states comprising Mexico have incorporated this definition in their legislation to allow women a violence-free life, defining obstetric violence as one of the "types" of violence that can be exercised against women (in addition to physical, sexual, psychological, inheritance, and economic violence). Moreover, in three states, obstetric violence is considered a felony: Veracruz (2012), Chiapas, and Guerrero (2014).

ORCID iD

Roberto Castro https://orcid.org/0000-0002-1440-2460

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Author Biographies

Roberto Castro, PhD, is a full professor at the Regional Center for Multidisciplinary Research (National Autonomous University of Mexico). He graduated with a BA in sociology from the National Autonomous University of Mexico. He received an MA in Population Studies from the University of Exeter. He received his PhD in Medical Sociology from the University of Toronto. He conducts research on violence against women, and on the subjective experience of violence, illness, and oppression. He has coordinated several national studies on violence against women and the State policies needed to prevent and eradicate it.

Sonia M. Frías, PhD, is a researcher and professor at the Regional Center for Multidisciplinary Research (National Autonomous University of Mexico). She received her PhD in Sociology from the University of Texas at Austin. She conducts research on gender equality, violence against women and children from a gender perspective, and the role of the State in protecting women and children from violence.